IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

BRIAN MOAT,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**Case No.: 3:21-cv-00807**
	)	
THE METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY, TENNESSEE,	)	**JUDGE TRAUGER**
	)	**JURY DEMAND**
	)	
Defendants.	)	

BUSINESS RECORDS AFFIDAVIT

Comes now Kimberly Jordan and states as follows:

1. I am employed by Davies as a Claims Manager My job duties include maintaining records for this business.

2. In my authority with Davies I have the authority to certify the attached records for Brian Moat

3. The attached records are true and accurate copies of all of the records described in Jesse Harbison Law's request for records sent on June 23rd, 2022.

4. The attached records were prepared by the personnel of Davies or persons acting under its control, in the ordinary course of their regularly conducted business at or near the time of the act, condition or event reported in the records and making the records was a regular practice.

5. It is the policy of Davies that the personnel preparing

Case 3:21-cv-00807 Document 23-2 Filed 05/05/23 Page 1 of 14 PageID #: 83

these records have knowledge of the information that is recorded in these records, and has a business duty to timely make and maintain true and accurate records.

6. The charge of $ / for furnishing these copies is reasonable.

Kimberly Jordan
BUSINESS RECORDS CUSTODIAN

STATE OF Tennessee)

COUNTY OF Davidson)

Personally appeared before me, the undersigned, a Notary Public, in and for said county and state, the within named Kimberly Jordan with whom I am personally acquainted (or upon the basis of satisfactory evidence presented to me), who, after being duly sworn, made oath that he/she executed the foregoing for the purposes therein contained.

WITNESS my hand and official seal this 7 day of July, 2022.

Karen June Jamian
Notary Public

KAREN JUNE JAMIAN
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires MARCH 3, 2026

My Commission Expires:

March 3, 2026

Form - 201
Injury On Duty (IOD) Report

Date: 12-13-19
Time In: 955 AM
Time Out: 11:00 AM
Front Desk Initials: CP

Facility: Metro IOD Clinic

Moat, Brian J.

Employer: Metro IOD Clinic-ONSITE ONLY
SSN: [redacted] DOB: 06/13/1968
Case Date: 12/12/2019

____ HOME #:_____

JJURY:_____ (INITIAL / RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: Dr. Rebecca Smith HOW WAS AUTHORIZATION OBTAINED? ASC

DESCRIPTION OF INJURY: acute lumbar disc herniation with radiculopathy + weakness

ASSESSMENT/DIAGNOSIS: " " " " "

Is condition claimed and compatible to be work related? ☒ Yes ☐ No
Known pre-existing or other conditions contributing? ☐ Yes ☐ No
TREATMENT RENDERED: xrays, referral

MEDICATIONS: (prescribed) Ø

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

____SENT HOME (UNABLE TO WORK)

____ADMITTED TO:_____

____LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE MUST BE BE OFF WORK UNTIL NEXT VISIT

UPPER EXTREMITY
____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over ____ lbs.
____No repetitive/heavy gripping
____No use of vibrating tools
____No repetitive/outstretched arm use

BACK
____Sitting job only
____Alternate sit/stand
____May stand/walk up to ____ hrs/day
____No repetitive stoop/bend/twist
____May stoop/bend/twist____times/hour
____Weight limit _____lbs.

LOWER EXTREMITY
___ Sitting job with foot/leg elevated
___Alternate sit/stand, may walk short distances
___No squatting or kneeling
___ No running/jumping
___ No climbing stairs/ladders

OTHER
____Keep dressing clean/dry
___No driving
___No use of hazardous machinery
___Must wear brace as directed
___Medications may cause drowsiness Do not take at work.

Additional notes:_____

DATE TO RETURN TO REGULAR DUTY:_____
FOLLOW UP APPT. REQUIRED? ☐ YES ☐ NO DATE:___/___/___ TIME:_____
If you need to reschedule, call 615-880-2400

REFERRAL TO SPECIALTY: Ortho Spine (Dr. Lebow) Staff Mgmt (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY:_____ (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING:_____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient Signature: _____ Date: 12-13-19 Provider Signature: _____

COMPLETED COPY WAS FAXED TO ASC AT 615-360-5692 FROM THE METRO IOD CLINIC. RETAIN COPY IN EMPLOYEE'S FILE.

Form - 201

Injury On Duty (IOD) Report

Date: 12/17/19
Time Out:

Facility: Howell Allen Clinic Medical Record #: Front Desk Initials:

EMPLOYEE NAME: MOAT, BRIAN J HOME #:

DATE OF BIRTH: 06/13/68 SS #: DEPARTMENT: FIRE/EMS BUREAU CLAIM # C503-19-63746 -01

DATE OF INJURY: 12/12/19 TIME OF INJURY: INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: Dr. Appollion HOW WAS AUTHORIZATION OBTAINED? THROUGH ASC

DESCRIPTION OF INJURY: LEFT HIP AND BACK

ASSESSMENT/DIAGNOSIS: L3-4 HERNIATED DISC

Is condition claimed and compatible to be work related? ☑ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ☑ No

TREATMENT RENDERED: EXAM

MEDICATIONS: (prescribed) HYDROCHLOROQUE, FLEXERIL, GABAPENTIN

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

✓ SENT HOME (UNABLE TO WORK)

____ADMITTED TO:

____LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

UPPER EXTREMITY
____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over ____ lbs.
____No repetitive/heavy gripping
____No use of vibrating tools
____No repetitive/outstretched arm use

LOWER EXTREMITY
____Sitting job with foot/leg elevated
____Alternate sit/stand, may walk short distances
____No squatting or kneeling

BACK
____Sitting job only
____Alternate sit/stand
____May stand/walk up to ____ hrs/day
____No repetitive stoop/bend/twist
____May stoop/bend/twist___times/hour
____Weight limit _____lbs.

OTHER
____Keep dressing clean/dry
____No driving
____No use of hazardous machinery
____Medications may cause drowsiness

Do not take _____ at work.

DATE TO RETURN TO REGULAR DUTY:

FOLLOW UP APPT. REQUIRED? ☑ YES ☐ NO AFTER SURGERY ☐ AS NEEDED DATE: ____/____/____ TIME: _____

REFERRAL TO SPECIALTY: (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: Brian J Moat Date: 12/17/19 Physician:

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Injury On Duty (IOD) Report

Date: 1/3/20
Time Out:
Facility: ___ Medical Record #: ___ Front Desk
Initials:

EMPLOYEE NAME: Brian Moat HOME #: 615-582-2615 WORK #:

DATE OF BIRTH: 6/13/68 SS #: DEPARTMENT:

DATE OF INJURY: 12/12/2019 TIME OF INJURY: INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: Dr Oran Aaronson HOW WAS AUTHORIZATION OBTAINED? through ASC

DESCRIPTION OF INJURY: Left hip + back

ASSESSMENT/DIAGNOSIS: no change

Is condition claimed and compatible to be work related? (Yes) No
Are known pre-existing or other conditions contributing? Yes (No)

TREATMENT RENDERED: surgery on 12/20/19

MEDICATIONS: (dispensed ___ /prescribed X) norco, gabapentin, flexeril

RETURN TO WORK OUTLINE

___RETURN TO REGULAR DUTY

___DISCHARGED FROM CARE

X SENT HOME (UNABLE TO WORK)

___ADMITTED TO:

___LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

DATE TO RETURN TO REGULAR DUTY:

UPPER EXTREMITY
- ___No use of injured hand/arm
- ___No repetitive overhead work
- ___No lift/push/pull over ___ lbs.
- ___No repetitive/heavy gripping
- ___No use of vibrating tools
- ___No repetitive/outstretched arm use

LOWER EXTREMITY
- ___Sitting job with foot/leg elevated
- ___Alternate sit/stand, may walk short distances
- ___No squatting or kneeling

BACK
- ___Sitting job only
- ___Alternate sit/stand
- ___May stand/walk up to ___ hrs/day
- ___No repetitive stoop/bend/twist
- ___May stoop/bend/twist___times/hour
- ___Weight limit ___lbs.

OTHER
- ___Keep dressing clean/dry
- ___No driving
- ___No use of hazardous machinery
- ___Medications may cause drowsiness
  Do not take ___ at work.

FOLLOW UP APPT. REQUIRED? (YES) NO AS NEEDED DATE: 1/30/20 TIME:

REFERRAL TO SPECIALTY: (ASC to make referral)

REFERRAL TO PHYSICAL THERAPY: (ASC to make referral)

Form - 201

Injury On Duty (IOD) Report

Date: 1/30/20
Time Out: _____
Facility: HOWELL ALLEN Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: BRIAN MOAT HOME #: 615-582-2615 WORK #: _____

DATE OF BIRTH: 6/13/65 SS #: _____ DEPARTMENT: FIRE

DATE OF INJURY: 12/12/19 TIME OF INJURY: _____ INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: DR. ABBOTSON HOW WAS AUTHORIZATION OBTAINED? THROUGH ASC

DESCRIPTION OF INJURY: _____

ASSESSMENT/DIAGNOSIS: S/P LUMBAR DISCECTOMY

Is condition claimed and compatible to be work related? ~~☐~~ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ~~☐~~ No
TREATMENT RENDERED: EXAM; ORDERED AFO

MEDICATIONS: (dispensed ____/prescribed ____) NONE

RETURN TO WORK OUTLINE

____ RETURN TO REGULAR DUTY

____ DISCHARGED FROM CARE

✓ SENT HOME (UNABLE TO WORK)

____ ADMITTED TO: _____

____ LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

DATE TO RETURN TO REGULAR DUTY: _____

UPPER EXTREMITY
____ No use of injured hand/arm
____ No repetitive overhead work
____ No lift/push/pull over ____ lbs.
____ No repetitive/heavy gripping
____ No use of vibrating tools
____ No repetitive/outstretched arm use

LOWER EXTREMITY
____ Sitting job with foot/leg elevated
____ Alternate sit/stand, may walk short distances
____ No squatting or kneeling

BACK
____ Sitting job only
____ Alternate sit/stand
____ May stand/walk up to ____ hrs/day
____ No repetitive stoop/bend/twist
____ May stoop/bend/twist ____ times/hour
____ Weight limit _____ lbs.

OTHER
____ Keep dressing clean/dry
____ No driving
____ No use of hazardous machinery
____ Medications may cause drowsiness
Do not take _____ at work.

FOLLOW UP APPT. REQUIRED? ☑ YES ☐ NO ☐ AS NEEDED DATE: ____/____/____ TIME: _____
REFERRAL TO SPECIALTY: _____ (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: 2 TIMES PER WEEK FOR 6 WEEKS (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: _____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 1/30/20 Physician: _____

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Form - 201

Date 11/21/20

Time In: _____

Time Out: _____

Injury On Duty (IOD) Report

Facility: Howell Allen Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: Brian Mott HOME #: 615-582-2615 WORK #: _____

DATE OF BIRTH: 6/13/68 Emp ID#: _____ DEPARTMENT: Fire

DATE OF INJURY: 12/12/19 TIME OF INJURY: _____ INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: Dr. Aaronson HOW WAS AUTHORIZATION OBTAINED? Nashville ASC

DESCRIPTION OF INJURY: _____

ASSESSMENT/DIAGNOSIS: S/P Lumbar discectomy

Is condition claimed and compatible to be work related? ~~☐~~ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ~~☐~~ No
TREATMENT RENDERED: exam

MEDICATIONS: (dispensed _____/prescribed _____) None

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

✓ SENT HOME (UNABLE TO WORK)

____ADMITTED TO: _____

____LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over __lbs.
____No repetitive/tight gripping
____No use of vibrating tools
____No repetitive/outstretched arm/hand use
____Sitting job with foot/leg elevated
____Stand/walk ___% of time
____ Alternate sit/stand, may walk short distances
____ No use of hazardous machinery
____ No squatting or kneeling
____ No running/jumping

____Sitting job only
____Alternate sit/stand ____mins/hr
____May stand/walk up to ____ hrs/day
____No repetitive stoop/bend/twist
____May stoop/bend/twist__ times/hour
____Weight limit _____lbs.
____ Sit ___% of the time

____Keep dressing clean/dry
____No driving company vehicles/bus
____No working heights/on ladders
____No safety sensitive duties

____Use brace/ walker/ orthotic/ cane/ crutches as needed (Please Circle)

FOLLOW UP APPT. REQUIRED? ☑ YES ☐ NO 4 months ☐ AS NEEDED DATE: ____/____/____ TIME: _____
REFERRAL TO SPECIALTY: _____ (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: _____ (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: _____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 11/21/20 Physician: _____

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Form - 201

Date 6/18/20

Time In: _____

Time Out: _____

Injury On Duty (IOD) Report

Facility: HOWELL ALLEN Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: BRIAN MOAT HOME #: 615-582-2615 WORK #: _____

DATE OF BIRTH: 6/13/68 Emp ID#: _____ DEPARTMENT: FIRE

DATE OF INJURY: 12/12/19 TIME OF INJURY: _____ INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: DR. PARKINSON HOW WAS AUTHORIZATION OBTAINED? THROUGH ASC

DESCRIPTION OF INJURY: _____

ASSESSMENT/DIAGNOSIS: S/P LUMBAR DISCECTOMY

Is condition claimed and compatible to be work related? ☒ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ☒ No
TREATMENT RENDERED: EXAM

MEDICATIONS: (dispensed_____/prescribed_____) NONE

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

____SENT HOME (UNABLE TO WORK)

____ADMITTED TO:_____

✓ LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT
AS OF 6/19/20

ERROR

- ✓ No use of injured hand/arm
- ✓ No ~~repetitive~~ overhead work
- ✓ No lift/push/pull over 25 lbs.
- ____No repetitive/tight gripping
- ____No use of vibrating tools
- ____No repetitive/outstretched arm/hand use
- ____Sitting job with foot/leg elevated
- ____Stand/walk ___% of time
- ____ Alternate sit/stand, may walk short distances
- ____ No use of hazardous machinery
- ✓ No squatting or kneeling
- ✓ No running/jumping

- ____Sitting job only
- ____Alternate sit/stand ____mins/hr
- ____May stand/walk up to ____ hrs/day
- ____No repetitive stoop/bend/twist
- ____May stoop/bend/twist__ times/hour
- ____Weight limit _____lbs.
- ____ Sit ___% of the time

- ____Keep dressing clean/dry
- ____No driving company vehicles/bus
- ____No working heights/on ladders
- ____No safety sensitive duties

____Use brace/ walker/ orthotic/ cane/ crutches as needed (Please Circle)

FOLLOW UP APPT. REQUIRED? ☒ YES ☐ NO ☐ AS NEEDED DATE:____/____/____ TIME: _____
REFERRAL TO SPECIALTY: _____ (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: _____ (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: _____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 6/18/20 Physician: _____

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Form - 201

Date 8/18/20

Time In: _____

Time Out: _____

Injury On Duty (IOD) Report

Facility: HOWELL ALLEN Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: BRIAN MOAT HOME #: 615-582-2615 WORK #: _____

DATE OF BIRTH: 6/13/68 Emp ID#: _____ DEPARTMENT: FIRE

DATE OF INJURY: 12/12/19 TIME OF INJURY: _____ INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: DR. AARONSON HOW WAS AUTHORIZATION OBTAINED? THROUGH ASC

DESCRIPTION OF INJURY: _____

ASSESSMENT/DIAGNOSIS: S/P LUMBAR DISCECTOMY

Is condition claimed and compatible to be work related? ☒ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ☒ No
TREATMENT RENDERED: EXAM

MEDICATIONS: (dispensed _____/prescribed _____)

RETURN TO WORK OUTLINE

___RETURN TO REGULAR DUTY

___DISCHARGED FROM CARE

___SENT HOME (UNABLE TO WORK)

___ADMITTED TO: _____

✓ LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

___No use of injured hand/arm
___No repetitive overhead work
✓ No lift/push/pull over 25 lbs.
___No repetitive/tight gripping
___No use of vibrating tools
___No repetitive/outstretched arm/hand use
___Sitting job with foot/leg elevated
___Stand/walk ___% of time
___ Alternate sit/stand, may walk short distances
___ No use of hazardous machinery
___ No squatting or kneeling
✓ No running/jumping

___Sitting job only
___Alternate sit/stand ___mins/hr
___May stand/walk up to ___ hrs/day
✓ No repetitive stoop/bend/twist
___May stoop/bend/twist__ times/hour
___Weight limit _____lbs.
___ Sit ___% of the time
___Keep dressing clean/dry
___No driving company vehicles/bus
___No working heights/on ladders
___No safety sensitive duties

___Use brace/ walker/ orthotic/ cane/ crutches as needed (Please Circle)

FOLLOW UP APPT. REQUIRED? ☒ YES ☐ NO NOVEMBER ☐ AS NEEDED DATE: ___/___/___ TIME: _____
REFERRAL TO SPECIALTY: _____ (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: CONTINUE PT (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: _____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 8/18/20 Physician: _____

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Form - 201
Injury On Duty (IOD) Report

Date: 9-8-20
Time In: 1044
Time Out: 12p.
Front Desk Initials: CP

Facility: Metro IOD Clinic

Moat, Brian J.

Employer: Metro IOD Clinic-ONSITE ONLY
SSN: [redacted] DOB: 06/13/1968
Case Date: 12/12/2019

FILE

_____ HOME #: _____

NJURY: _____ INITIAL / RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: Dr. Rebecca Smith HOW WAS AUTHORIZATION OBTAINED? ASC

DESCRIPTION OF INJURY: left medial ankle swelling, painful rolling, medial malleolus fx, metatarsal

ASSESSMENT/DIAGNOSIS: _____

Is condition claimed and compatible to be work related? ☐ Yes ☐ No
Known pre-existing or other conditions contributing? ☐ Yes ☐ No
TREATMENT RENDERED: exam, xray, crutches

MEDICATIONS: (prescribed) _____

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

____SENT HOME (UNABLE TO WORK)

____ADMITTED TO: _____

UPPER EXTREMITY
____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over ____ lbs.
____No repetitive/heavy gripping
____No use of vibrating tools
____No repetitive/outstretched arm use

BACK
____Sitting job only
____Alternate sit/stand
____May stand/walk up to ____ hrs/day
____No repetitive stoop/bend/twist
____May stoop/bend/twist ____ times/hour
____Weight limit _____ lbs.

__L__LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE MUST BE BE OFF WORK UNTIL NEXT VISIT

LOWER EXTREMITY
___ Sitting job with foot/leg elevated
___Alternate sit/stand, may walk short distances
___No squatting or kneeling
___ No running/jumping
___ No climbing stairs/ladders

OTHER
____Keep dressing clean/dry
___No driving
___No use of hazardous machinery
___Must wear brace as directed
____Medications may cause drowsiness Do not take at work.

Additional notes: Sitting 75% of time, weight bearing as tol w/ crutches / brace

DATE TO RETURN TO REGULAR DUTY: _____
FOLLOW UP APPT. REQUIRED? ☐ YES ☒ NO DATE: ____/____/____ TIME: _____
If you need to reschedule, call 615-880-2400
REFERRAL TO SPECIALTY: Ortho (foot/ankle) assume care (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: _____ (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: _____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 9-8-20 Physician: _____

COMPLETED COPY WAS FAXED TO ASC AT 615-360-5692 FROM THE METRO IOD CLINIC. RETAIN COPY IN EMPLOYEE'S FILE.
EMPLOYEE TO RETURN COPY TO SUPERVISOR.

Injury On Duty (IOD) Report

Date: 4/22/20

Time Out: _____

Facility: VUMC Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: Bryan J. Moar HOME #: 615.582.2615 WORK #: _____

DATE OF BIRTH: 13 JUN 68 SS #: [redacted] DEPARTMENT: FIRE

DATE OF INJURY: 12 TIME OF INJURY: _____ INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: GALLAGHER HOW WAS AUTHORIZATION OBTAINED? ASC

DESCRIPTION OF INJURY: (L) Posterior Tibial Tendon injury

ASSESSMENT/DIAGNOSIS: (L) Posterior Tibial Tendon injury

Is condition claimed and compatible to be work related? • Yes • No
Are known pre-existing or other conditions contributing? • Yes • No
TREATMENT RENDERED: PT

Patient can return to full unrestricted PT

MEDICATIONS: (dispensed_____/prescribed_____)

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

X SENT HOME (UNABLE TO WORK)

____ADMITTED TO:_____

____LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

DATE TO RETURN TO REGULAR DUTY:_____

UPPER EXTREMITY
____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over ____ lbs.
____No repetitive/heavy gripping
____No use of vibrating tools
____No repetitive/outstretched arm use

LOWER EXTREMITY
____Sitting job with foot/leg elevated
____Alternate sit/stand, may walk short distances
____No squatting or kneeling

BACK
____Sitting job only
____Alternate sit/stand
____May stand/walk up to ____ hrs/day
____No repetitive stoop/bend/twist
____May stoop/bend/twist___times/hour
____Weight limit _____lbs.

OTHER
____Keep dressing clean/dry
____No driving
____No use of hazardous machinery
____Medications may cause drowsiness
Do not take _____ at work.

FOLLOW UP APPT. REQUIRED? • YES • NO • AS NEEDED DATE: after MRI ____/____/____ TIME: _____

REFERRAL TO SPECIALTY:_____(ASC to make referral)

REFERRAL TO PHYSICAL THERAPY:_____(ASC to make referral)

REFERRAL TO DIAGNOSTIC TESTING: MRI (L) ankle (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 9/22/20 Physician: _____

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Form - 201

Injury On Duty (IOD) Report

Date: 11/24/20
Time Out:
Facility: HOWELL ALLEN CLINIC Medical Record #: Front Desk Initials:

EMPLOYEE NAME: BRIAN MOAT HOME #: 615-382-2615 WORK #:

DATE OF BIRTH: 6/13/68 SS #: DEPARTMENT: FIRE

DATE OF INJURY: 12/12/19 TIME OF INJURY: INITIAL/~~RECHECK~~ (PLEASE CIRCLE)

TREATING PHYSICIAN: DR. AARONSON HOW WAS AUTHORIZATION OBTAINED? THROUGH ASC

DESCRIPTION OF INJURY:

ASSESSMENT/DIAGNOSIS: S/P LUMBAR DISCECTOMY

Is condition claimed and compatible to be work related? ~~☐~~ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ~~☐~~ No
TREATMENT RENDERED: EXAM

MEDICATIONS: (dispensed ____ /prescribed ____) NONE

RETURN TO WORK OUTLINE

____ RETURN TO REGULAR DUTY

____ DISCHARGED FROM CARE

____ SENT HOME (UNABLE TO WORK)

____ ADMITTED TO:

✓ LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

DATE TO RETURN TO REGULAR DUTY:

UPPER EXTREMITY
- ____ No use of injured hand/arm
- ____ No repetitive overhead work
- ✓ No lift/push/pull over 25 lbs.
- ____ No repetitive/heavy gripping
- ____ No use of vibrating tools
- ____ No repetitive/outstretched arm use

LOWER EXTREMITY
- ____ Sitting job with foot/leg elevated
- ____ Alternate sit/stand, may walk short distances
- ✓ No squatting or kneeling

BACK
- ____ Sitting job only
- ____ Alternate sit/stand
- ____ May stand/walk up to ____ hrs/day
- ✓ No repetitive stoop/bend/twist
- ____ May stoop/bend/twist ____ times/hour
- ____ Weight limit ____ lbs.

OTHER
- ____ Keep dressing clean/dry
- ____ No driving
- ____ No use of hazardous machinery
- ____ Medications may cause drowsiness Do not take ____ at work.

FOLLOW UP APPT. REQUIRED? ~~☐~~ YES ☐ NO 3 MONTHS ☐ AS NEEDED DATE: ____/____/____ TIME:
REFERRAL TO SPECIALTY: (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: WORK HARDENING TWICE PER WEEK 6 WEEKS (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: Date: 11/24/20 Physician:

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.

Form - 201

Date 3/9/21

Time In: _____

Time Out: _____

Injury On Duty (IOD) Report

Facility: HOWELL ALLEN Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: BRIAN MOAT HOME #: 615-582-2615 WORK #: _____

DATE OF BIRTH: 6/13/68 Emp ID#: _____ DEPARTMENT: FIRE

DATE OF INJURY: 12/12/19 TIME OF INJURY: _____ INITIAL/RECHECK (PLEASE CIRCLE)

TREATING PHYSICIAN: DR. AARONSON HOW WAS AUTHORIZATION OBTAINED? THROUGH DAVIES

DESCRIPTION OF INJURY: _____

ASSESSMENT/DIAGNOSIS: S/P LUMBAR DISCECTOMY

Is condition claimed and compatible to be work related? ~~☐ Yes~~ ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ~~☐ No~~
TREATMENT RENDERED: EXAM

MEDICATIONS: (dispensed_____/prescribed_____) NONE

RETURN TO WORK OUTLINE

✓ RETURN TO REGULAR DUTY

✓ DISCHARGED FROM CARE

___ SENT HOME (UNABLE TO WORK)

___ ADMITTED TO: _____

___ LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

___ No use of injured hand/arm
___ No repetitive overhead work
___ No lift/push/pull over __lbs.
___ No repetitive/tight gripping
___ No use of vibrating tools
___ No repetitive/outstretched arm/hand use
___ Sitting job with foot/leg elevated
___ Stand/walk ___% of time
___ Alternate sit/stand, may walk short distances
___ No use of hazardous machinery
___ No squatting or kneeling
___ No running/jumping

___ Sitting job only
___ Alternate sit/stand ____mins/hr
___ May stand/walk up to ____ hrs/day
___ No repetitive stoop/bend/twist
___ May stoop/bend/twist__ times/hour
___ Weight limit _____lbs.
___ Sit ___% of the time
___ Keep dressing clean/dry
___ No driving company vehicles/bus
___ No working heights/on ladders
___ No safety sensitive duties

___ Use brace/ walker/ orthotic/ cane/ crutches as needed (Please Circle)

FOLLOW UP APPT. REQUIRED? ☐ YES ☐ NO ~~☐~~ AS NEEDED DATE: ____/____/____ TIME: _____
REFERRAL TO SPECIALTY: _____ (ASC to make referral)
REFERRAL TO PHYSICAL THERAPY: WORK HARDENING 2 TIMES PER WEEK FOR 8 WEEKS (ASC to make referral)
REFERRAL TO DIAGNOSTIC TESTING: _____ (ASC to make referral)

I understand this report and acknowledge receipt of a copy:

Patient: _____ Date: 3/9/21 Physician: _____

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.